FORM HPCE-2
IN-HOME HOSPICES
09/2009

THIS REPORT MUST BE FILED PRIOR TO OR WITH YOUR CON APPLICATION
**2007 REPORT**

Appendix - B

# STATE HEALTH PLANNING AND DEVELOPMENT AGENCY


*MAILING ADDRESS (U.S. Postal Service)*
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4109
www.shpda.alabama.gov

*STREET ADDRESS (Commercial Carrier)*
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
paul.may@shpda.alabama.gov


## 2007 ANNUAL REPORT FOR IN-HOME HOSPICES

**Mailing Address:** _____ (STREET ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

**Physical Address:** _____ (STREET ADDRESS) _____ (CITY) **AL** _____ (ZIP)

**County of Location:** _____

**Facility Telephone:** _____ ((AREA CODE) & TELEPHONE NUMBER) **Facility Fax:** _____ ((AREA CODE) & TELEPHONE NUMBER)

This reporting period is for October 1, 2006, through September 30, 2007*; or for partial year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

*Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. ***If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.***

***We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this provider.***

| PRINTED NAME OF PREPARER | SIGNATURE OF PREPARER | DATE |
|---|---|---|
| DIRECT TELEPHONE NUMBER | TITLE OF PREPARER | E-MAIL ADDRESS |

***A member of administration <u>MUST</u> also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above.***

| PRINTED NAME OF ADMINISTRATION OFFICIAL | SIGNATURE OF ADMINISTRATION OFFICIAL | DATE |
|---|---|---|
| DIRECT TELEPHONE NUMBER | TITLE OF ADMINISTRATION OFFICIAL | E-MAIL ADDRESS |

**FOR OFFICE USE ONLY**

| | | | | | |
|---|---|---|---|---|---|
| Facility Verified: | | Initial Scan: | | Completed: | |
| Entered: | | Final Scan: | | Audited: | |

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# I. PROGRAM DEMOGRAPHICS

## A. Agency Type

_____ Free Standing
_____ Home Health Based
_____ Government/Healthcare Authority Based
_____ Hospital Based
_____ Nursing Home Based

## B. Ownership

_____ Corporation
_____ Individual
_____ Joint Venture
_____ Non-Profit Organization
_____ Healthcare Authority
_____ Government
_____ Partnership
_____ LLC
_____ Other (specify) _____

## C. Reporting Entity

**1.** Does this agency have the capability to provide patient information, specific only to this licensed location? _____ **YES** _____ **NO**

**2**. If no, provide the name of the licensed hospice agency that will be reporting patient information for this entity:

**SHPDA ID #:** _____

**NAME OF REPORTING HOSPICE:** _____

**NAME OF CONTACT:** _____

**TELEPHONE NUMBER:** _____

**3.** Will the information contained in this report include patient information from other licensed hospice agencies, for services offered and performed in the State of Alabama? _____ **YES** _____ **NO**

**4.** If yes, provide the SHPDA ID # and the name of the licensed hospice agency(ies) for which information is included in this report:

| **SHPDA ID #:** | **NAME OF HOSPICE AGENCY** |
|---|---|
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# II. ADMISSIONS

## A. ADMISSIONS BY COUNTY OF RESIDENCE

(This data should reflect all patients served during the reporting period, including those in nursing facilities. Information should be provided by county of residence. Attach additional sheets as necessary.)

| COUNTY | NUMBER OF ADMISSIONS | NUMBER OF DEATHS | NUMBER OF NON-DEATH DISCHARGES | NUMBER OF PATIENTS SERVED (include carryover from the prior year) | ROUTINE HOME CARE DAYS | CONTINUOUS CARE DAYS | INPATIENT CARE DAYS | RESPITE CARE DAYS | TOTAL CARE DAYS (sum of routine home, continuous, inpatient & respite care days |
|---|---|---|---|---|---|---|---|---|---|
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| **TOTALS** | ** | | | | | | | | |

****TOTAL NUMBER OF ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS II-C, AND II-D.**

## B. PATIENT DAYS BY PAYMENT SOURCE

Provide the number of patient days for all patients including those in hospitals, specialty care assisted living, and nursing facilities, for the reporting period.

| HOSPICE PAYMENT SOURCE | NUMBER OF PATIENTS SERVED | DAYS OF ROUTINE HOME CARE | DAYS OF INPATIENT CARE | DAYS OF RESPITE CARE | DAYS OF CONTINUOUS CARE | TOTAL PATIENT CARE DAYS |
|---|---|---|---|---|---|---|
| Hospice Medicare | | | | | | |
| Hospice Medicaid | | | | | | |
| Private Insurance/ Managed Care (non-Medicare) | | | | | | |
| Charity/ Indigent | | | | | | |
| Private Pay | | | | | | |
| Other (VA, Worker's Comp, etc) | | | | | | |
| **TOTALS** | | | | | | |

## C. ADMISSIONS BY DEMOGRAPHICS

Use the patient's age on the first day of admission.

| AGE GROUPS | MALE | FEMALE | TOTAL |
|---|---|---|---|
| **18 and under** | | | |
| **19 – 34** | | | |
| **35 – 54** | | | |
| **55 – 64** | | | |
| **65 – 74** | | | |
| **75 – 84** | | | |
| **85 years and older** | | | |
| **TOTAL ADMISSIONS** | | | ** |

****TOTAL ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS II-A AND II-D.**

## D. TOTAL ADMISSIONS BY RACE

| RACE | ADMISSIONS |
|---|---|
| **a. White/Caucasian** | |
| **b. Black/African American/Negro** | |
| **c. Hispanic/Spanish/Latino** | |
| **d. Asian** | |
| **e. American Indian/Alaskan Native** | |
| **f. Pacific Islander** | |
| **g. India** | |
| **h. Middle Eastern** | |
| **i. Other** | |
| **TOTAL ADMISSIONS** | ** |

****TOTAL ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS II-A, AND II-C.**

## III. REVENUES AND EXPENSES (***AMOUNTS DO NOT HAVE TO BE AUDITED)***

| EXPENSES | | REVENUES | |
|---|---|---|---|
| Payroll | $ .00 | Medicare | $ .00 |
| Non-Payroll | $ .00 | Medicaid | $ .00 |
| Transportation | $ .00 | Commercial Insurance | $ .00 |
| Bad Debt | $ .00 | Private Pay | $ .00 |
| Charity | $ .00 | Other | $ .00 |
| **TOTAL EXPENSES** | $ .00 | **TOTAL REVENUES** | $ .00 |